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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/14/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Caudal Epidural Steroid Injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Orthopedic Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is this reviewer's opinion that the request for Caudal Epidural Steroid injection is not recommended as medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a xx year old who was injured on xx/xx/xx. The patient developed complaints of low back pain radiating to the left lower extremity. This was initially treated with physical therapy, muscle relaxants, and anti-inflammatories with no significant improvement. Prior MRI studies of the lumbar spine from xxxx noted disc bulging and facet arthropathy at L4-5. There was some mild right sided foraminal stenosis noted at this level without central stenosis. No significant stenosis at L3-4 or at L5-S1 was noted. The patient did undergo 1 epidural steroid injection at the L4-5 interlaminar space on xxxx. The follow up report on xxxx indicated the patient had significant improvement on the day of the injection; however, there was no documented long term relief. The patient's physical examination noted tenderness in the lumbar region with a positive straight leg raise sign to the left. No other focal neurological deficit was noted. The patient wished to try a caudal epidural steroid injection to improve overall symptoms.

The requested epidural steroid injection was denied on xxx and xxxx; however, no specific opinion regarding the denial was noted.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for complaints of low back pain radiating to the left lower extremity. The most recent physical examination findings did not identify any clear evidence of any left sided radiculopathy. MRI studies of the lumbar spine also found no evidence of significant left sided nerve root impingement at the L4-5 level. The patient's last epidural steroid injection was an interlaminar injection with no long term relief or functional improvement. A caudal epidural steroid injection is a different approach; however, without evidence of clear radiculopathy in this case, it is this reviewer's opinion that the request for Caudal Epidural Steroid injection is not recommended as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)